RFS 7-99
SOLICITATION FOR INSURANCE PROVIDERS
ATTACHMENT F

RESPONSIBILITIES OF THE STATE

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RESPONSIBILITIES OF THE STATE

1.0 Eligibility and Enrollment

Individuals will be able to apply for the health care coverage plan established under House Bill 1678 (the "Program") through the Division of Family Resources (DFR) and other authorized enrollment venues (such as hospitals, health clinics and other entities). However, as described in Section 4.1 of Attachment D to the RFS, the primary path for enrollment will be through the Plans. In order to fulfill this enrollment function, Plans may wish to contract with authorized, private enrollment entities that have previous experience enrolling children and families in Hoosier Healthwise and may be interested in expanding their services to serve the Program's eligible populations.

1.1 Eligibility Determination

Regardless of which path an individual uses to apply for the Program, the State remains responsible for making final eligibility determinations. When an applicant applies for the Program through a Plan or other authorized enrollment venue, DFR will make a final eligibility determination within 45 days of receiving completed application materials (including supporting documentation). The plan selection and required POWER Account contribution amount calculation will also be processed in this timeframe. The Plan will receive notification of the eligibility determination for each individual it helps apply for the Program.

If an individual applies for enrollment in another FSSA program, such as Hoosier Healthwise, but does not qualify, the State will screen the applicant for eligibility in the Program. The State will also provide parents enrolling their children in SCHIP with information about the Program.

The State is currently in the process of outsourcing its front-end application processing functions for all FSSA programs. The new application system will be rolled-out on a regional basis, and the goal is that this system will be fully operational by mid-2008. Individuals interested in applying for the Program will be able to use the new application system. Under the new system, individuals will be able to apply for the Program by completing a web-based application or by contacting a central Call-In Center. Individuals will also be able to mail or fax application materials to a central Document Center.

The new DFR application system will be available for Plans to use when helping individuals apply for the Program.

Section 4.1 of Attachment D to this RFS provides further detail regarding Member Eligibility and Enrollment.

1.1.1 Managing High Risk Populations

Applicants will be asked to complete a "general health questionnaire" during the application process. This questionnaire will be used by the State to identify whether an individual has one or more "high-risk conditions," as defined by OMPP. If the State determines that the applicant has at least one "high-risk condition," the applicant will not be enrolled in a Plan providing services under this RFS. Instead of being enrolled in a Plan providing services under this RFS, the applicant will be enrolled in the State's high-risk plan, a separate plan that specializes in managing high-risk populations. The State's high-

risk plan provides the same benefit package as other plans participating in the Program, plus additional disease management.

Plans will be given an opportunity to notify the State when they believe an individual enrolled in their Plan belongs in the State's high-risk plan. This notice may occur within 30 days after the individual's coverage under the Plan begins and at the end of each coverage term. For example, after an individual's coverage under the Plan begins (i.e., after the individual's first POWER Account payment is processed), Plans will have 30 days to request that the State transfer the individual into the State's high-risk plan (even if the general health questionnaire did not indicate the existence of a high-risk condition during enrollment, so long as the member in fact has a high-risk condition). The Plan's request should be supported by a physical examination or initial claims data. If the State does not receive the Plan's request within 30 days after the member's coverage under the Plan begins, however, the individual must remain in the Plan for the rest of the coverage term. At the end of the coverage term, the Plan will have another opportunity to use prior claims data and/or a physical exam to support a request to the State for moving the member into the State's high-risk plan. The State may also refer an individual from the high risk plan back to a Plan if it is determined that the individual does not have a high-risk condition within 30 days of enrollment.

To summarize, the Plan may submit a request to the State that a member be disenrolled from the Plan and enrolled in the State's high-risk plan 1) within 30 days after the member's coverage under the Plan begins and 2) at the end of each coverage term. The ultimate decision of whether to move an individual from the Plan into the State's high-risk plan, however, lies with the State.

During the redetermination process at the end of each coverage term, enrollees in the Program will be asked to fill out another "general health questionnaire." If the general health questionnaire indicates that the member developed a "high-risk condition" over the course of the coverage term, the State may require that the member be disenrolled from the Plan and enrolled in the State's high-risk plan instead.

The general rule is that all family members eligible for the Program must enroll in the same Plan. However, if a family member enrolls in the State's high-risk plan, this rule does not apply. Only the family member determined to be high-risk will enroll in the State's high-risk plan. Other family members eligible in the Program will be enrolled in a Plan providing services under this RFS.

The cases of individuals participating in the State's high-risk plan will be reviewed annually, and on an as-needed basis, to determine if a positive change in their health condition warrants disenrollment from the State's high-risk plan and enrollment into one of the Plans providing services under this RFS.

A DRAFT list of high risk conditions for referral to the State's high-risk plan is provided in the Bidder's Library. This list is subject to change.

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1.2 Member Linkage to Plans and Plan Enrollment

Applicants that apply for the Program through the Plans will make their plan selection during the application process. DFR will notify the Plan of its final eligibility determination within 45 days of receiving a completed application (including supporting documentation).

Applicants that do not apply through the Plans—but apply for the Program through other venues, such as DFR or other authorized enrollment locations—will receive information about available Plan options from the State. Like applicants that apply for the Program through the Plans, they will have to make their plan selection during the application process. If an applicant fails to make a Plan choice, they will be auto-assigned to a Plan according to an auto-assignment process developed by the State. Please see Section 1.2.1 below for further information about the auto-assignment process.

After an individual to Plan linkage occurs, either by self-selection or auto-assignment, the State or the State's agent will inform the Plan. As soon as the individual makes his or her first required contribution to the POWER Account, the member's coverage will begin. After receiving notice of DFR's final eligibility determination, the Plan may be asked to provide an eligibility notification to all individuals it assisted in applying for the Program, as well as for individuals that applied for the Program through other venues and selected or were auto-assigned to the Plan. The first contribution to the member's POWER Account must not exceed one-twelfth (1/12) of the member's annual required contribution amount. Coverage under the Plan begins on the 1st day of the coverage month after the payment is received, or, if payment is made by check, the check clears. The Plan will not be financially responsible for the member until the first POWER Account contribution is processed.

Section 4.1 of Attachment D to this RFS provides further detail regarding Member Eligibility and Enrollment.

1.2.1 Auto-assignment to the Plan

If an individual does not choose a plan during the application process, the State's fiscal agent will assign the member to a plan through a systematic auto-assignment process. Auto-assignments will be made on a rotating basis. The State reserves the right to make auto-assignments based on plan performance and/or the lowest cost plan after year one.

The State's enrollment policies and procedures prohibit discriminating against individuals eligible to enroll on the basis of race, color, national origin, ancestry, disability, age, sex, religion, health status or the need for health care services, and the State will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, ancestry, disability, age, sex, religion, health status or the need for health care services, in accordance with 42 CFR 438.6(d) and federal and state civil rights laws. The Plan may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs or a change in a member's health care status, with the exception of requesting the State to move members with high-risk conditions into the State's high-risk plan as described in Section 1.1.1 above. A

member's health care utilization patterns may not serve as the basis for disenrollment from the Plan.

1.2.2 Enrollment Rosters

OMPP's fiscal agent will notify each Plan of all members enrolled in the Plan. The fiscal agent will generate daily Plan Member Enrollment Rosters using information obtained from the DFR's ICES transmissions, and Plan assignments entered into the Indiana*AIM* system during member enrollment and the auto-assignment process. The Plan Member Enrollment Rosters provide the Plans with a detailed listing of all members for whom the Plan is, will be or has been responsible for (i.e., new, continuing and terminated enrollees).

The Plan is responsible for reconciling the enrollment roster with capitation payments and State POWER Account contributions received. If a Plan receives enrollment information, a capitation payment and/or the State's POWER Account contribution for a member, the Plan is financially responsible for the member as soon as the member makes his or her first scheduled contribution to the POWER Account. Coverage under the Plan begins on the 1st day of the coverage month after the payment is received, or, if payment is made by check, the check clears.

The State's fiscal agent's eligibility verification systems, which are updated daily, must be used in the event of any discrepancies. The Plan discovering eligibility/capitation/ POWER Account contribution discrepancies shall notify the fiscal agent within 30 calendar days of discovering the discrepancy and no more than 90 calendar days after the Plan receives the eligibility records.

1.2.3 Plan Member Enrollment Limitations

To ensure member choice of health plans and availability of PMPs, the State reserves the right to monitor enrollment in the Plan. The State may also monitor the actual panel sizes of each of the Plan's PMPs. If a determination is made to restrict Plan enrollment, the State will notify the Plan in advance of implementing member enrollment limitations. The State may retard Plan member enrollment growth by excluding the Plan from receiving auto-assignments.

If enrollment limitations are invoked, the State will evaluate Plan member enrollment each month to determine when any of the member limitations may be lifted.

1.3 POWER Accounts

The State is responsible for making the final determination of an individual's required POWER Account contribution amount and will notify the Plan accordingly. The State will make its entire contribution to the POWER Account promptly after receiving notice from the Plan that the member's first POWER Account contribution has been processed.

Section 3.0 of Attachment D to this RFS provides further detail regarding POWER Accounts.

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1.4 Member Disenrollment

1.4.1 12-Month Member Lock-In

Members will be locked into a Plan for a period of 12-months. However, 42 CFR 438.56 permits members to request disenrollment from the Plan for cause at any time or as the result of a Corrective Action levied against the Plan, as indicated in Section 9.1.1 of Attachment D to the RFS.

1.4.2 Changing Plans

At the end of a 12-month coverage term, members will have 30 calendar days from the date they are redetermined to be eligible for the Program to change Plans. The Plan must provide notice to members of their right to change plans 60 days prior to the end of the coverage term, in accordance with 42 CFR 438.10(f).

As described in Section 4 of Attachment D to the RFS, individuals will also be permitted to change plans before their first POWER Account contribution is made.

1.4.3 Disenrollment by the Plan

Members will be disenrolled from the Program and the Plan for any one of the following reasons:

- The member fails to make the required monthly POWER Account contribution within 60 days of its due date
- The member is determined ineligible for the Program at redetermination
- The member obtains access to employer sponsored coverage
- The member becomes covered under another health insurance policy or FSSA program (with the exception of coverage for pregnancy-related services under Hoosier Healthwise Package B)

The member may also be disenrolled from the Plan (but not the Program) if, based on a general health questionnaire, physical examination or claims data, the State confirms that a member has a high-risk condition that requires referral into the State's high-risk plan, as described in Section 1.1.1 above.

The Plan must not request a member's disenrollment from the Plan because of an adverse change in the member's health status, utilization of medical services, diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs (unless the member's continued enrollment seriously impairs the Plan's ability to provide services to the member or other members), with the exception of requesting the State to move members with high-risk conditions into the State's high-risk plan as described in Section 1.1.1 above.

If a member is disenrolled from the Plan, the Plan must disable the member's pre-paid debit card immediately.

1.4.4 Disenrollment by the Member

A member may request disenrollment from the Plan in the following circumstances:

- It is the end of the 12-month coverage period and the member requests a plan change, in accordance with Section 1.4.2 above.
- Before the first POWER Account contribution is made.
- For cause, at any time. Causes for disenrollment include the following:
    - The Plan does not, because of moral or religious objections, cover the service the member seeks.
    - The member needs related services to be performed at the same time and not all related services are available within the Plan's network and the member's PMP or other provider determines that receiving the services separately would subject the member to unnecessary risk.
    - Other reasons, including poor quality of care, lack of access to services covered under the contract or lack of access to providers experienced in dealing with the member's health care needs.

The member must submit his or her request for disenrollment to the Plan orally or in writing. The Plan may approve the request or refer the request to the State. If the request is referred to the State, the State may require the member to seek redress through the Plan's grievance system before making a determination. If used, the grievance process must be completed in the timeframes specified in 42 CFR 438.56(e)(1).

If the Plan or the State fails to make a determination by the first day of the second month following the month in which the member files the request, the disenrollment will be considered approved and the member will be transferred into the new plan.

If a member is disenrolled from the Plan, the Plan must disable the member's pre-paid debit card immediately.

Section 4.1 of Attachment D to this RFS provides further detail regarding member disenrollment.

1.5 Provider Enrollment

The Plan must ensure that its provider network is supported by written agreements, is available, is geographically accessible and provides adequate numbers of facilities, physicians, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members. The State considers all providers as eligible to participate in the Program when the provider enrolls with the Indiana Health Coverage Programs (IHCP), and all Plan providers

must first be enrolled as IHCP providers before providing services to the Plan's members. The State allows physicians to contract as PMPs, specialists and ancillary providers in any number of Plans.

1.6 Provider Network File

During the readiness review process, and on a monthly basis thereafter, the Plan must provide to the fiscal agent in an electronic file in a specified format a list of all providers, including PMPs and specialists, enrolled in the Plan.

1.7 Ongoing Plan Monitoring

OMPP and/or its monitoring contractor will review and monitor Plan performance on a regular basis and identify non-compliance with the program requirements and performance standards outlined in this RFS and its Attachments. OMPP conducts monitoring activities through site visits, document review, review of performance data and analysis of shadow claims data, among other mechanisms.

OMPP reserves the right to change or modify the reporting requirements, evaluation instruments and enforcement policies, as necessary, at any time during the contract period with sufficient notice to the Plan resulting from its monitoring activities or changes in Federal or State requirements.

OMPP, or duly authorized agents of the State or Federal government, reserves the right to inspect, audit, monitor or otherwise evaluate the performance of the Plan or its subcontractors during normal business hours, at the Plan's or its subcontractors' premises. OMPP will conduct regular on-site reviews, and these reviews may include an audit of financial or operational systems and data.

In addition, OMPP complies with the external quality review regulations for monitoring managed care organizations set forth in 42 CFR 438.350.

Please see Section 8.0 of Attachment D to this RFS for further detail regarding Plan monitoring activities.

1.8 Evaluating Plan Solvency

The Indiana Department of Insurance (IDOI) maintains the primary responsibility for monitoring the Plan's solvency and financial status. In addition, OMPP monitors the Plan's solvency status in accordance with Federal regulations described in 42 CFR 438.116.

Please see Sections 1.5 and 8.1 of Attachment D to the RFS for further detail regarding financial monitoring.

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1.9 Making Payments to the Plan

OMPP pays Plans participating in the Program a monthly capitation payment for each enrolled member. Capitation rates are based on the member's age and gender and are set forth in Attachment G of the RFS.